Patient Information

PATIENT NAME: ____ **DATE:** ___________________

Nickname: ____________________________ Age: ______ Date of Birth: _________________________

Married __ Single__ Divorced__ Widowed__ Name of Spouse or Parent if Patient is a Minor _________________

Address:____

(Number-Street) *(City-State)* *(Zip)*

Occupation:_____________________________________ Social Security Number:___________________________

Place of Employment:____

Home Phone:__________________________ Work Phone:__________________ Cell Phone:__________________

Email Address: *(optional)* ____

Reason for visiting our office?____

List Major Medical Problems: *(Check if you currently have, or have had in the past)*

High Blood Pressure ___	Stomach Ulcers/Reflux ___	Bleeding Problems____	Hearing Loss____
Chronic Bronchitis/Emphysema ___	Hay fever ____	Bladder Disease____	
Diabetes Mellitus____	Kidney Disease ___	Seizures ____	
Heart Disease____	Prostate Disease ____	Tuberculosis ____	
Asthma____	Glaucoma____	Cancer___ If yes, where?_______________	

List all Previous Surgeries:____

List Known Allergies:____

Family History: List relationship to you if **Yes** is checked

Diabetes	Yes___No___	____________	Tuberculosis	Yes___No___	____________
Asthma	Yes___No___	____________	Bleeding Problems	Yes___No___	____________
Hay Fever/Allergies	Yes___No___	____________	Hearing Loss	Yes___No___	____________
Cancer	Yes___No___	____________			

Do You Smoke? I Quit___ When?______ Never____ Cigarettes____ Cigars____ Pipe____ Snuff or Chew_____

Do You Consume Alcohol? None_____ _Less than 1 per Day _____1-2 per Day_____ More than 2 per Day_____

Other Medical Problems:____

Do you require pre-medication prior to surgical procedures? Yes____ No___

What Doctor referred you to Our Practice?____

HIPAA PRIVACY ACT

Who may we discuss your medical test results and your condition with other than yourself?___________________________

I hereby authorize the examination and treatment and authorize the release of medical information to insurance or Medicare carriers. I will be responsible for payment of services my insurance or Medicare does not cover (non-covered) services performed with my permission in this office that my insurance company has contracted to another provider or facility. I will be responsible for knowing the providers and facilities in my insurance company's network and for accepting referrals to only these providers and facilities. If I accept a referral to a provider or facility outside my insurance network, I will be responsible for any charges not covered by my insurance company or Medicare. I hereby authorize my insurance benefits be paid directly to FLORIDA GULF COAST EAR, NOSE & THROAT, LLC. A copy of this authorization is as valid as the original. I understand I have the right to review FLORIDA GULF COAST EAR, NOSE & THROAT, LLC'S Notice of Privacy Practices, located in the waiting room, and to obtain a copy by asking the receptionist. I also give permission for FLORIDA GULF COAST EAR, NOSE & THROAT, LLC to discuss my medical test results and condition with the individual(s) listed above.

Signature of Patient, Parent, or Legal Guardian:____**Date:**______________